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Getting Started

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Responding

- Simple changes for the PD:
- Information about board eligibility
- Just (look it up and) do it
Responding

• Simple changes for the PD:
• Logistical changes
• Complex changes
• Changes needing resources
• Faculty expectation changes
• Culture changes
Responding

- Simple changes for the PD:
- Information about board eligibility
Responding

- Logistical changes:
- Confidentiality of evaluations
- Verification of training
- PEC duties
- Set up a system/process with your APDs, coordinators, other program directors, institution
Responding

• Complex changes:
• QI and safety scholarship experience
• Needs collaboration with other departments, may need to work with other PDs, may to change the culture
Responding

- Resource changes:
- Lactation rooms, Coordinator support, new rotation at new site
- Need to identify needs for institution for budgeting
Responding

- Faculty expectations:
- PD annual review of faculty
- Monitor all sites
- Need to work with key faculty or core faculty or CCC to decide how to identify and communicate new expectations
What do I do?

- List
- Categorize
- Prioritize: for you, program, department, SI,
- Find allies: residents, staff, faculty, in and outside department
What do I do?

- Get some short term wins
- Start some long term aspirations
- Learn/borrow from others
- Set a time table
- “Project management”
Section I: Oversight

- I B3 Program must monitor clinical learning and working environment at all sites
  - Includes a faculty member who is accountable for resident education at each participating site
- I C Mission-driven, ongoing, systematic recruitment and retention of diverse workforce
Section I: Oversight

• Identification of PRs that mirror the Institutional Requirements:

  • Access to food
  • Sleep and rest facilities
  • Security and safety measures
  • New PR addressing lactation facilities
  • New PR requiring accommodations for residents with disabilities, consistent with Sponsoring Institution policy.
Section I E: Oversight

• Other learners and providers:

• *Residency version:* The presence of other learners and other care providers, including, but not limited to, residents from other specialties, subspecialty fellows, and advanced practice care providers, must enrich the appointed residents’ education.

• …must report when other learners interfere to DIO and GMEC
Section I: Oversight

• **Fellowship version:** Fellows should contribute to the education of residents in core programs, if present.
  
  • Emphasizes program responsibility to ensure:
  • Fellows’ education is not compromised by the presence of other providers and learners
  • Fellows’ education does not compromise core residents’ education
II A: PD Support

- Residency and fellowship versions now address PD support – previously addressed in some, not all, specialty PRs

- **Residency version:** Minimum 20% FTE (8h/per week) salary support for program administration (RC may specify)

- **Fellowship version:** PD must be provided with support adequate for program administration based on program size and configuration (RC must specify)
II A3: PD Qualifications

• Qualifications must include:
  • *At least 3 years of educational and/or administrative experience, or qualifications acceptable to RC (residency version only)*
  • AOA or ABMS certification acceptable
  • *Current medical licensure and medical staff appointment (residency version only)*
  • *Ongoing clinical activity (residency version only)*
II A4: PD Responsibilities

- Be a role model of professionalism
- Design and conduct program consistent with community needs and mission(s) of the program and SI
- Program curriculum should address community needs and health disparities
II A4: PD Responsibilities

- Develop and oversee process for evaluation of candidates for program faculty prior to appointment and annually thereafter
- Have authority to appoint and remove faculty at all sites
- Have authority to remove residents from supervising interactions that do not meet program standards
II A4: PD Responsibilities

• Provide applicants with information related to board eligibility

• Provide an environment in which residents may confidentially raise concerns and provide feedback without fear of intimidation or retaliation
II A4: PD Responsibilities

• Ensure compliance with SI’s policies and procedures on employment and non-discrimination
  • No restrictive covenants or non-competition guarantees for residents
II A4: PD Responsibilities

• Document and provide, upon request:
  • Verification of residency education within 30 days of program completion
  • Summative evaluation of residency education for all residents
II B2: Faculty Responsibilities

• Be role models of professionalism
• Demonstrate commitment to safe, quality, cost-effective, patient-centered care
• Pursue faculty development at least annually
II B2g: Faculty Development

- **Residency version**: Faculty development to enhance skills:
  - As educators
  - In quality improvement and patient safety
  - In fostering well-being
  - In patient care based on PBLI efforts
II B3: Faculty Qualifications

- AOA certification acceptable
- Any non-physician faculty member must be designated by the program director
II B4: Core Faculty

- Definition now based on role in resident education and supervision – not number of hours devoted
- Includes, at a minimum, CCC and PEC members
- Must complete annual ACGME Faculty Survey
II B4 Core Faculty

• Non-physician faculty members may be appointed as core faculty

• Scholarly activity now assessed for the program as a whole, not individual core faculty (allows core faculty selection based on educational contributions)
II C: Program Coordinator

- *New* - There must be a program coordinator
  - *Support for coordinator now required for all programs*
II C: Program Coordinator

Background and Intent:

Program coordinator is the lead administrative person
Member of the leadership team
Title varies across institutions
Responsibilities vary based on needs of the program
Programs should encourage professional development for coordinators
II C: Program Coordinator

- *Residency version*: Support for the coordinator must be at least 50% FTE (at least 20 hours per week) for administrative time (RCs may further specify)

- *Fellowship version*: Support must be adequate for program administration, based on program size and configuration – (RCs may specify minimum level of support)
Section III: Eligibility

- Eligibility criteria from Institutional Requirements now mirrored in Common Program Requirements

- *Residency version:* ACGME-I Advanced Specialty accreditation acceptable for prerequisite clinical education
Section III: Eligibility

- **Fellowship version**: RC to decide on prerequisite education accredited by:
  - Option 1: ACGME, AOA, RCPSC, CFPC or ACGME-I Advanced Specialty Accreditation
  - Option 2: ACGME or AOA only

- RC may elect to permit exceptions regardless of which eligibility option is chosen (mostly IMGs)
IV A: Curriculum

• New program aims
• Goals and objectives for autonomy
• Protected time for core didactics
• Ethical principles for professionalism
IV C: Curriculum organization

- Structured to optimize length of experiences and supervisory continuity
- Pain management and signs of addiction
IV D: Scholarship

- New scholarship section replaces previous faculty and resident scholarly activity sections
- Focus on scholarly activity for the program as a whole
- Scholarly activity must be consistent with the mission of the program
IV D2 Scholarly Activity

Programs must have efforts in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case report

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IV D2 Scholarly Activity

• Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials

• Contribution to professional committees, educational organizations, or editorial boards

• Innovations in education
The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods [each RC chose (1) or (1 and 2)]

- (1) *faculty participation in grand rounds, poster presentations, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;* (Outcome)

- (2) *peer-reviewed publication.* (Outcome)
IV D3 Scholarly Activity

- *Residency version only* - Residents must participate in scholarship. Each graduating resident should have a scholarly activity that is disseminated as further described in IV.D.2.b).(1) or IV.D.2.b).(2). (RC may further specify)

- *Fellowship version* – No common requirement for fellow scholarly activity – RC may specify requirements
Section IV: Independent Practice

• New PR for Fellowship version only:
  • Fellowship programs may assign fellows to engage in the independent practice of their core specialty during their fellowship.
  • If programs permit their fellows to utilize the independent practice option, it must not exceed 20 percent of their time per week or 10 weeks of an academic year. (Core)
    • (The Review Committee may further specify)
V A: Resident Evaluation

• PD or designee, with input from CCC, must:
  • Meet with and review with each resident documented semi-annual evaluation, including Milestones progress
  • Assist residents in developing individualized learning plans
  • Develop plans for residents failing to progress

• Provide summative evaluation of resident’s readiness to progress to the next year of the program
V C: Program Evaluation

- Addition of list of required elements to be addressed in the Annual Program Evaluation
- PEC must evaluate the program’s mission and aims, strengths, areas for improvement, and threats
V C: Program Evaluation

• Annual review, including action plan, must be:
  • Distributed to and discussed with faculty and residents
  • Reviewed by the GMEC

• Program must complete a Self-Study prior to 10-year accreditation site visit
V C3: Board Certification

- PD should encourage graduates to take applicable ABMS or AOA certification examination—*replaces all existing specialty-specific take rate requirements*
V C3: Board Certification

• Board pass rate (for both written and oral exams):
  • Aggregate pass rate of first time takers
  • Three years of data for an annual exam
  • Six years of data for a biennial exam
V C: Board Certification

Program are OK if either one:

1. Pass rate is above the bottom 5\textsuperscript{th} percentile
2. First time taker pass rate equal to 80 percent no matter the percentile rank of the program.

Programs must report in ADS the ultimate board certification rates annually for the cohort of residents that graduated seven years earlier.
Take home points:

- More flexibility for fellowships
- More flexibility about scholarship
- More about wellness and quality and safety
- More emphasis on faculty development
- More detail about program evaluation
- More consistency about board pass rate
CPRs Summary

- Ambitious changes, some aspirational
- Emphasis on improving the Clinical Learning Environment
- Review committees still developing interpretation
- Time to start working on the changes, use the intent.
- Same goal as before: independent practice....
  .......for a life-time
CPRs – Questions?
Section VI

- Includes philosophy and rationale behind requirements (italicized)
- “Duty hours” replaced with “the learning and working environment”
VI F1. Maximum Hours

- 80-hour weekly maximum remains
- Clinical work from home counts toward 80 hours
- Charting at home and other physician work
- Responding to patient care questions
- Planned didactics
- Moonlighting counts
  - Reminder: averaged over 4 weeks
VI F1. Maximum Hours

• What does NOT count toward 80 hours
  • At home reading done to prep for next day
  • At home studying and learner work
  • At home research

• Above counts toward 80 hours when done in the hospital or site
VI F1. Maximum Hours

• Does all of at-home call period count toward “clinical work done from home?”
  • NO! Only the time devoted to patient care activities
VI.A.1.d).(1) Appointments

Residents must be given the opportunity to attend medical, dental, mental health, and dental care appointments, including those scheduled during their working hours.

- **Intent** is to ensure that residents may attend appointments as needed, and that their schedules not prevent them from seeking care
- **Institution policies** dictate whether vacation/sick time must be used
- **Common sense and reasonableness should prevail**
VI C1e(3) 24/7 access to mental health professionals

- Residents must have immediate access to a mental health professional
- In-person, telemedicine, or telephonic access is acceptable
- Resident Assistance Program like EAP
Section VI

- VI.A.1.a).(4)(a): All residents must receive training in how to disclose adverse events to patients and families.
  - Many ways to meet this requirement
  - Participating is acceptable, but so are simulations
  - Review Committee believes that having faculty model examples is appropriate as well.
Section VI

• VI.A.1.b).(2).(a): Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.
  • *Examples: case volumes,*
Section VI

• Home Call

• Understand certain subspecialties are on call for 7 days
• “Averaged over a 4-week period”
• A weekend break between 2 2-week periods would meet the requirement
• PGY-1 residents may be scheduled for in-house and at-home call
Take home points:

More flexibility for fellowships
More flexibility about scholarship
More about wellness and quality and safety
More emphasis on faculty development
More emphasis on the 80 hours
More aspirational requirements about diversity
CPRs – Questions?